

REFERRAL FORM

<p>Patient Details:</p> <p>Surname: _____</p> <p>Given Name(s): _____</p> <p>Address: _____</p> <p>Postcode: _____ Phone: _____</p> <p>DOB: _____ Age: _____</p> <p>Country of Birth: _____</p> <p>Cultural Identity: _____</p> <p>Main Language Spoken: _____</p> <p><i>Note: If client does not speak English, they are required to have an English speaking relative / friend attend</i></p> <p>Reason for Referral:</p> <p><i>Note: Please refer to patient criteria on the reverse of this form</i></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Mobility Status: _____</p> <p>_____</p> <p>Relevant Medical History: _____</p> <p>_____</p> <p>_____</p> <p>Medications Currently in Use: _____</p> <p>_____</p> <p>_____</p> <p>If Referred from Other Hospital, Date of Discharge: _____</p> <p>Comments:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Private Health Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, Name of Insurer: _____</p> <p>Membership No: _____</p> <p>Level of Cover: _____</p> <p>DVA Card Holder: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, DVA No. _____</p> <p>Colour of Card: _____</p> <p>Consultant (if appropriate):</p> <p>Name: _____</p> <p>Has Consultant approved patient for Day Rehabilitation? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>General Practitioner: _____</p> <p>Address: _____</p> <p>Postcode: _____ Phone: _____</p> <p>Referring Person:</p> <p>Name: _____</p> <p>Profession: _____</p> <p>Address: _____</p> <p>Postcode: _____ Phone: _____</p> <p>Emergency Contact:</p> <p>Name: _____</p> <p>Address: _____</p> <p>Postcode: _____ Phone: _____</p> <p>Relationship to Patient: _____</p> <p>Patient consented to referral:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <hr/> <p>Hospital Use Only</p> <p>Date received: _____</p> <p>Date Sent for Health Fund Check: _____</p>
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Admission Criteria

Patient must:

- have the potential to benefit from participating in a Day Rehabilitation Program which may include hydrotherapy
- have Private Health Insurance cover or DVA cover
- be able to complete an exercise programme in a supervised environment
- be continent if attending hydrotherapy
- be independent or have own carer to assist with showering and / or dressing if attending hydrotherapy
- arrange their own transport to and from the hospital

Referral Requirements

- referral from a health care professional
- if referral is from another hospital a Discharge Summary is to be sent on the day of the patient's discharge
- if being referred from another hospital, the patient's specialist / consultant is to be aware of and consent to the referral